Billing Instructions (Hospice)

Last Updated: 04/28/2022

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Billing Instructions (Hospice)

The purpose of this chapter is to explain the procedures for billing the Virginia Medicaid Program.

Two major areas are covered in this chapter:

General Information - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.

Billing Procedures - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

Electronic Submission of Claims

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information contact our fiscal agent,

Conduent:

Phone: (866)-352-0766

Fax number: (888)-335-8460

Website: https://vamedicaid.dmas.virginia.gov/edi or by mail

Conduent:

EDI Coordinator

Virginia Medicaid Fiscal Agent

P.O. Box 26228

Richmond, Virginia 23260-6228

Billing Instructions: Direct Data Entry

As part of the 2011 General Assembly Appropriation Act - 300H which requires that all new providers bill claims electronically and receive reimbursement via Electronic Funds Transfer (EFT) no later than October 1, 2011 and existing Medicaid providers to transition

to electronic billing and receive reimbursement via EFT no later than July 1, 2012, DMAS has implemented the Direct Data Entry (DDE) system. Providers can submit claims quickly and easily via the Direct Data Entry (DDE) system. DDE will allow providers to submit Professional (CMS-1500), Institutional (UB-04) and Medicare Crossover claims directly to DMAS via the Virginia Medicaid Web Portal. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQs can be accessed from our web portal at: www.vamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider.

(This Section is under Review - March 2022)

Timely Filing (Podiatry)

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations [42 CFR § 447.45(d)] to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. Submission is defined as actual, physical receipt by DMAS. In cases where the actual receipt of a claim by DMAS is undocumented, it is the provider's responsibility to confirm actual receipt of a claim by DMAS within 12 months from the date of the service reflected on a claim. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

Retroactive Eligibility - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment

is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

Delayed Eligibility - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted. The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Denied claims – Denied claims must be submitted and processed **on or before thirteen months from date of the initial denied claim where the initial claim was filed within the 12 months limit to be** considered for payment by Medicaid. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.
- **Attach** written documentation to justify/verify the explanation. This documentation may be continuous denials by Medicaid or any dated follow-up correspondence from Medicaid showing that the provider has actively been submitting or contacting Medicaid on getting the claim processed for payment. Actively pursuing claim payment is defined as documentation of contacting DMAS at least every six months. Where the provider has failed to contact DMAS for six months or more, DMAS shall consider the resubmission to be untimely and no further action shall be taken. If billing

electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits)

Accident Cases - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursement.

Other Primary Insurance - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursements. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

Other Insurance - The member can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid member. For members with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while the member has Medicaid without penalty from their insurance company. The members must notify the insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

Submit the claim in the usual manner by mailing the claim to billing address noted in this chapter.

Billing Invoices (Hospice)

The requirements for submission of physician billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below is the billing invoice to be used:

- Health Insurance Claim Form, CMS-1450 (UB-04)

The requirement to submit claims on an original CMS-1450 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice. Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid.

Nursing Facility Residents

For dates of service on or after July 1, 2015, hospice providers furnishing services to nursing facility residents must submit Resource Utilization Group (RUG) codes on the claim. The hospice provider must obtain the RUG billing information from the nursing facility.

The RUG code must be reported in the first three digits of the Health Insurance Prospective Payment System (HIPPS) rate code locator on the UB-04 form. The type of assessment (reason for assessment) or modifier should be reported in the last two digits of the HIPPS rate code. The total charges reported for revenue code 0022 should be zero.

The occurrence code and assessment reference date should be reported in the occurrence code and the occurrence span and date locators.

Claims will continue to be billed on the UB-04 claim form, the 8371 electronic format, or

entered through Direct Data Entry by the provider as currently billed.

Hospice providers bill DMAS for room and board for fee for service (FFS) members. For dates of service 7/1/2019 and after, the Hospice provider does not bill CCC Plus MCOs for nursing facility room and board charges. The nursing facility must bill the MCO directly for these charges and not the hospice provider.

Service Intensity Add-On Payment

For dates of service on or after January 1, 2016, A Service Intensity Add-On (SIA) payment equal to the Continuous Home Care Hourly rate has been established for services provided by a Registered Nurse or Social Worker within the last 7 days of the member's life.

Claims must be submitted with a separate single line item entry for each eligible date of service along with a combination of revenue code 0551- "Skilled Nursing Visit" and procedure code G0299 which is defined as "direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting" and/or revenue code 0561 - Medical Social Service Visit and procedure code "G0155" which is defined as "Services of clinical social worker in home health or hospice settings, each 15 minutes." The SIA payment is provided for visits of a minimum of 15 minutes and a maximum of 4 hours per day, i.e. from 1 unit to a maximum of 16 units combined for both nursing visit time and/or social worker visit time per day. In addition, the time of a social worker's phone calls is not eligible for an SIA payment. Visits made after the member's death should be reported with the "PM" – post mortem modifier, to be considered for the SIA payment. Providers must also utilize a discharge status of 20 (expired) or 40 (expired at home) to be reimbursed for the SIA payment.

Claims will continue to be billed on the UB-04 claim form, the 8371 electronic format, or entered through Direct Data Entry by the provider as currently billed.

Automated Crossover Claims Processing (Hospice)

Most claims for dually eligible members are automatically submitted to DMAS. The Medicare claims processor will submit claims based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as "crossovers" since the claims are automatically crossed over from Medicare to Medicaid.

To make it easier to match to providers to their Virginia Medicaid provider record, providers are to begin including their NPI Provider Number as a secondary identifier on the claims sent to Medicare. When a crossover claim includes a NPI Provider Number, the claim will be processed by DMAS using the NPI Provider Number. This will ensure the appropriate Virginia Medicaid provider is reimbursed.

When providers send in the 837 format, they should instruct their processors to include the Virginia Medicaid provider number and use qualifier "ID" in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the NPI Provider Number on the original claim to Virginia Medicare will reduce the need for submitting follow-up paper claims.

Effective March 26, 2007 (NPI dual use) DMAS will no longer attempt to match a Medicare provider number to a Medicaid provider number. If an NPI is submitted, DMAS will "only" use this number. DMAS has established a special email address for providers to submit questions and issues related to the Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmas.virginia.gov.

Requests for Billing Materials

Health Insurance Claim Form CMS-1500 (02-12)

The CMS-1500 (02-12) is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from form printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Print Office
Superintendent of Documents
Washington, DC

20402

(202)512-1800 (Order and Inquiry Desk)

Note: The CMS-1500 (02-12) will not be provided by DMAS.

The request for forms or Billing Supplies must be submitted by: Mail Your Request To:

Commonwealth Mailing 1700 Venable St.,

Richmond, VA 23223

Calling the DMAS order desk at Commonwealth Martin 804-780-0076 or, by faxing the DMAS order desk at Commonwealth Martin 804-780-0198

All orders must include the following information:

- Provider Identification Number
- Company Name and Contact Person
- Street Mailing Address (No Post Office Numbers are accepted)
- Telephone Number and Extension of the Contact Person
- The form number and name of the form
- The quantity needed for each form

Please DO NOT order excessive quantities.

Direct any requests for information or questions concerning the ordering of forms to the address above or call: (804) 780-0076.

Remittance/Payment Voucher (Hospice)

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

Claim Inquiries and Reconsideration

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long-distance (toll-free)

Member verification and claim status may be obtained by telephoning:

1-800- 772-9996	Toll-free throughout the United States
1-800- 884-9730	Toll-free throughout the United States
1-804- 965-9732	Richmond and Surrounding Counties
1-804- 965-9733	Richmond and Surrounding Counties

Member verification and claim status may also be obtained by utilizing the Web-based Automated Response System. See Chapter I for more information.

Billing Procedures (CMH)

Physicians and other practitioners must use the appropriate claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid members. Each member's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services

Practitioner

P.O. Box 27444

Richmond, Virginia 23261-7444

Or

Department of Medical Assistance Services
CMS Crossover
P. O. Box 27444
Richmond, Virginia 23261-7444

Billing Instructions: Electronic Filing Requirements

DMAS is fully compliant with 5010 transactions and will no longer accept 4010 transactions after March 30, 2012.

The Virginia MMIS will accommodate the following EDI transactions according to the specification published in the Companion Guide version 5010

270/271 Health Insurance Eligibility Request/ Response Verification for Covered Benefits (5010)

276/277 Health Care Claim Inquiry to Request/ Response to Report the Status of a Claim (5010)

277 - Unsolicited Response (5010)

820 - Premium Payment for Enrolled Health Plan Members (5010)

834 - Enrollment/ Disenrollment to a Health Plan (5010)

835 - Health Care Claim Payment/ Remittance (5010)

837 - Dental Health Care Claim or Encounter (5010)

837 - Institutional Health Care Claim or Encounter (5010)

837 - Professional Health Care Claim or Encounter (5010)

NCPDP - National Council for Prescription Drug Programs Batch (5010)

NCPDP - National Council for Prescription Drug Programs POS (5010) Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

All 5010/D.0 Companion Guides are available on the web portal: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides or contact EDI Support at 1-866-352-0766 or Virginia.EDISupport@conduent.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

For providers that are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent’s website: https://www.virginiamedicaid.dmas.virginia.gov.

UB-04 (CMS-1450) BILLING INSTRUCTIONS

Instructions for completing the UB-04 cms-1450 claim form

DMAS will allow the use of this claim form beginning with claims received on or after April 1, 2007.

Locator		Instructions
1	**Provider Name, Address, Telephone Required**	**Provider Name, Address, Telephone** - Enter the provider's name, complete mailing address and telephone number of the provider that is submitting the bill and which payment is to be sent. Line 1. Provider Name Line 2. Street Address Line 3. City. State, Line 4. Zip Code- **NOTE:** DMAS will need to have the 9 digit zip code on line four, left justified for adjudicating the claim if the provider has provided only one NPI and the servicing provider has multiple site locations for this service. **Note**: DMAS **does not** require telephone/fax numbers.
2	**Pay to Name & Address Required if Applicable**	**Pay to Name & Address** - Enter the address of the provider where payment is to be sent, if different than Locator 1.
3a	**Patient Control Number Required**	**Patient Control Number** - Enter the patient's unique financial account number which does not exceed 20 alphanumeric characters.
3b	**Medical/Health Record Required**	**Medical/Health Record** - Enter the number assigned to the patient's medical/health record by the provider. This number cannot exceed 24 alphanumeric characters.
4	**Type of Bill Required**	**Type of Bill** - Enter the code as appropriate. Valid codes for Virginia Medicaid are: 0811 Original Inpatient Nursing Home Hospice Invoice 0812 Interim Inpatient Nursing Home Hospice Claim Form* 0813 Continuing Inpatient Nursing Home Hospice Claim Invoice* 0814 Last Inpatient Nursing Home Hospice Claim Invoice* 0817 Adjustment Inpatient Nursing Home Hospice Invoice 0818 Void Inpatient Nursing Home Hospice Invoice
	Note:	For the above bill types, the revenue code that is billed for Nursing Facility services which are provided by Hospice is 0658- Nursing Facility Resident 0821 Original Inpatient Hospital Hospice Invoice 0822 Interim Inpatient Hospital Hospice Claim Form* 0823 Continuing Inpatient Hospital Hospice Claim Invoice* 0824 Last Inpatient Hospital Hospice Claim Invoice* 0827 Original Inpatient Hospital Hospice Invoice Adjustment 0828 Original Inpatient Hospital Hospice Invoice- Void
	Note:	For the above bill types, the revenue code that is billed for Inpatient Hospital Hospice Services which are provided by Hospice is 0655 - Inpatient Respite Care. 0831 Original Outpatient Invoice 0837 Adjustment Outpatient Invoice 0838 Void Outpatient Invoice

Locator		Instructions
		These below are for Medicare Crossover Claims Only
	Note:	For the above bill types, the revenue code that is billed for Nursing Home Outpatient Services which are provided by Hospice are 0651- Routine Home Care **OR** 0652 - Continuous Home Care.
5	Federal Tax Number Not Required	Federal Tax Number - The number assigned by the federal government for tax reporting purposes
6	**Statement Covered Period Required**	**Statement Covered Period -** Enter the beginning and ending service dates reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day.
7	Reserved for assignment by the NUBC	Reserved for assignment by the NUBC **NOTE: This locator on the UB 92 contained the covered days of care. Please review locator 39 for appropriate entry of the covered and non-covered days.**
8	**Patient Name/Identifier Required**	**Patient Name/Identifier** - Enter the last name, first name and middle initial of the patient on line b. Use a comma or space to separate the last and first name.
9	Patient Address	Patient Address **-** Enter the mailing address of the patient. 1. Street address 2. City 3. State 4. Zip Code (9 digits) 5. Country Code if other than USA
10	**Patient Birthdate Required**	**Patient Birthdate -** Enter the date of birth of the patient. Note: The format for birthdate is MMDDYYYY. This is the only locator that the 4-digit year is to be used.
11	**Patient Sex Required**	**Patient Sex -** Enter the sex of the patient as recorded at admission, outpatient or start of care service. M = male; F = female and U = unknown
12	**Admission/Start of Care Required**	**Admission/Start of Care -** The start date for this episode of care. For general Hospice this date is the date hospice began. For patients already in a nursing home facility, but elect hospice services the date hospice care began is to be entered. NOT the admission date to the nursing home.
13	**Admission Hour Required**	**Admission Hour -** Enter the hour during which the patient was admitted for inpatient or outpatient care. **Note**: Military time is used as defined by NUBC.

Locator		Instructions
14	**Priority (Type) of Visit Required**	**Priority (Type) of Visit -** Enter the code indicating the priority of this admission/visit. Appropriate codes accepted by DMAS for hospice are: **Code** — **Description** 3 — Elective **-** patient's condition permits adequate time to schedule the services 9 — Information not available
15	**Source of Referral for Admission or Visit Required**	**Source of Referral for Admission or Visit -** Enter the code indicating the source of the referral for this admission or visit. **Note:** Appropriate codes accepted by DMAS are: **Code:** — **Description** 1 — Physician Referral 2 — Clinic Referral 4 — Transfer from Another Acute Care Facility 5 — Transfer from a Skilled Nursing Facility 6 — Transfer from Another Health Care Facility (long term care facilities, rehabilitative and psychiatric facility 9 — Information not available
16	**Discharge Hour Required**	**Discharge Hour -** Enter the code indicating the discharge hour of the patient from inpatient care. **Note:** Military time is used as defined by NUBC
17	**Patient Discharge Status Required**	**Patient Discharge Status -** Enter the code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill (statement covered period, locator 6). Note: If the patient was a one-day stay, enter code "01". Appropriate codes accepted by DMAS are: **Code** — **Description** 01 — Discharged to Home 02 — Discharged/transferred to Short term General Hospital for Inpatient Care 03 — Discharged/transferred to Skilled Nursing Facility 04 — Discharged/transferred to Intermediate Care Facility 05 — Discharged/transferred to Another Facility not Defined Elsewhere 07 — Left Against Medical Advice or Discontinued Care 20 — Expired 30 — Still a Patient 50 — Hospice – Home 51 — Hospice – Medical Care Facility 61 — Discharged/transferred to Hospital Based Medicare Approved Swing Bed

Locator		Instructions
18 thru 28	**Condition Codes Required if applicable**	**Condition Codes** – Enter the code(s) in alphanumeric sequence used to identify conditions or events related to this bill that may affect adjudication. **Note**: DMAS limits the number of condition codes to maximum of 8 on one claim. These codes are used by DMAS in the adjudication of claims: **Code** **Description** 39 Private Room Medically Necessary 40 Same Day Transfer A1 EPSDT A4 Family Planning
29	**Accident State**	**Accident State** – Enter if known the state (two digit state abbreviation) where the accident occurred.
30	**Crossover Part A Indicator**	**Note:** DMAS is requiring for Medicare Part A crossover claims that the word **"CROSSOVER"** be in this locator
31 thru 34	**Occurrence Code and Dates Required if applicable**	**Occurrence Code and Dates –** Enter the code and associated date defining a significant event relates to this bill. Enter codes in alphanumeric sequence. An example of how providers should identify Medicare coverage exhausted on a Medicaid claim is A3= MDCR Exhaust
35 thru 36	**Occurrence Span Code and Dates Required if applicable**	**Occurrence Span Code and Dates –** Enter the code and related dates that identify an event relating to the payment of the claim. Enter codes in alphanumeric sequence. **For nursing facility residents, report occurrence span code (50) and the Medicaid Assessment Reference Date (ARD) date in the occurrence span dates for each RUG code. Multiple occurrence code 50 entries and occurrence span dates may be entered.**
37	Reserved	Reserved For NUBC Assignment
38	Responsible Party Name and Address	Responsible Party Name and Address – Enter the name and address of the party responsible for the bill.

Locator		Instructions
39 thru 41	**Value codes and Amount Required**	**Value Codes and Amount -** Enter the appropriate code(s) to relate amounts or values to identify data elements necessary to process this claim. **Note:** DMAS will be capturing the number of covered or non-covered day(s) or units for inpatient and outpatient service(s) with these required value codes: 80. Enter the number of covered days for inpatient hospitalization or the number of days for re-occurring outpatient claims. 81. Enter the number of non-covered days for inpatient hospitalization **AND** One of the following codes **must** be used to indicate the coordination of third party insurance carrier benefits: 82. No Other Coverage 83. Billed and Paid (enter amount paid by primary carrier) 85. Billed Not Covered/No Payment For Part A Medicare Crossover Claims, the following codes must be used with one of the third party insurance carrier codes from above: A1 Deductible from Part A A2 Coinsurance from Part A Other codes may also be used if applicable. The a, b, or c line containing this above information should Cross Reference to Payer Name (Medicaid) in Locator 50 A, B, C.
42	**Revenue Code Required**	**Revenue Codes** - Enter the appropriate revenue code(s) for the service provided. Note: • Revenue codes are four digits, leading zero, left justified and should be reported in ascending numeric order, • Multiple services for the same item, providers should aggregate the service under the assigned revenue code and then the total number of units that represents those services, • DMAS has a limit of five pages for one claim, • The Total Charge revenue code (0001) should be the last line of the last page of the claim. 0651 Routine home care is in-home care that is not continuous (less than 8 hours per day). (one unit = 1 day) Note: As of January 1, 2016, a higher base payment for the first 60 days of hospice care and a reduced base payment rate for days 61 and thereafter 0652 Continuous home care consists of in-home care that is predominantly nursing care and is provided as short-term crisis care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home care. (one unit = 1 hour)

Locator		Instructions
		0655 Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice or hospital) to relieve the primary caregiver(s) providing in-home care for the recipient. No more than five consecutive days of respite care will be allowed (one unit = 1 day). Payment for the sixth day and any subsequent days of respite care is made at the routine home care rate (Z9430). 0656 General inpatient care may be provided in an approved freestanding hospice or hospital. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting. (one unit = 1 day) 0658 Nursing facility resident who elected the hospice benefit (one unit = 1 day). Revenue code 0658 must be billed in conjunction with either revenue code 0651 (routine home care) or 0652 (continuous home care), which are billed as outpatient services with bill type 0831. Claims must also contain one revenue code 0022 for each distinct billing period of the nursing facility stay. Effective with dates of service 07/01/2019 and after, Hospice providers will be reimbursed 100% of the Medicaid per diem rate for the nursing facility in addition to reimbursement for either routine or continuous home care. 0551 Skilled Nursing Visit – to be used when submitting charges representative of a visit by a Registered Nurse within the member's last 7 days of life. Revenue code 0551 must be billed in conjunction with procedure code G0299.(one unit = 15 minutes, max 16 per day). Note: a corresponding 0651 – Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment. 0561 Medical Social Service Visit – to be used to be used when submitting charges representative of a visit by a Clinical Social Worker within the member's last 7 days of life. Revenue code 0561 must be billed in conjunction with procedure code G0155 (one unit = 15 minutes, max 16 per day). Note: a corresponding 0651 – Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment.
43	**Revenue Description Required**	**Revenue Description -** Enter the standard abbreviated description of the related revenue code categories included on this bill.

Locator		Instructions
44	**HCPCS/Rates/ HIPPS Rate Codes Required (if applicable)**	**HCPCS/Rates/HIPPS Rate Codes -** Inpatient: Enter the accommodation rate. For nursing facility residents, report the RUG code in the first three digits HIPPS rate code locator and the assessment code (reason for assessment) or modifier in the last two digits of the HIPPS rate code. Outpatient: The following codes are to be used only when submitting charges applicable to and for consideration of the SIA Payment. G0299 - direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting. G0155 - Services of clinical social worker in home health or hospice settings, each 15 minutes.
45	**Service Date Required if applicable**	**Service Date -** Enter one line item entry per revenue code for each date the outpatient service was provided.
46	**Service Units Required**	**Service Units -** Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate. Outpatient: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit). For nursing facility residents, the total accommodation days for revenue code 0658 should equal total units for each revenue code 0022 line.
47	**Total Charges Required**	**Total Charges -** Enter the total charge(s) for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges include both covered and non covered charges. **Note:** Use code “0001” for TOTAL. For nursing facility residents, the total charges for revenue code 0022 should be zero.
48	**Non-Covered Charges Required if applicable**	**Non-Covered Charges -** To reflect the non-covered charges for the primary payer as it pertains to the related revenue code.
49	Reserved	Reserved for Assignment by the NUBC.
50	**Payer Name A-C. Required**	**Payer Name -** Enter the payer from which the provider may expect some payment for the bill. A Enter the primary payer identification. B Enter the secondary payer identification, if applicable. C Enter the tertiary payer if applicable. When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C. This also applies to the Temporary Detention and Emergency Custody Order claims.

Locator		Instructions
51	Health Plan Identification Number A-C	Health Plan Identification Number **-** The number assigned by the health plan to identify the health plan from which the provider might expect payment for the bill. **NOTE:** DMAS will no longer use this locator to capture the Medicaid provider number. Refer to locators 56 and 57.
52	Release of Information Certification Indicator A-C	Release of Information Certification Indicator - Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization.
53	Assignment of Benefits Certification Indicator A-C	Assignment of Benefits Certification Indicator - Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.
54	**Prior Payments – Payer A,B,C Required (if applicable)**	**Prior Payments Payer** – Enter the amount the provider has received (to date) by the health plan toward payment of this bill.
55	Estimated Amount Due A,B,C,	Estimated Amount Due – Payer – Enter the amount by the provider to be due from the indicated payer (estimated responsibility less prior payments).
56	**NPI Required**	**National Provider Identification** – Enter your NPI. Once DMAS is in the dual use period (March 26, 2007), providers will submit their NPI in this locator on the UB 04. Until March 26, 2007, providers should enter their legacy Medicaid number in locator 57.
57A thru C	**Other Provider Identifier Required (if applicable)**	**Other Provider Identifier** – Enter your legacy Medicaid provider number in this locator until DMAS is accepting NPI for claims processing which are claims submitted prior to March 26, 2007. After NPI Compliance, DMAS will not accept claims received with the legacy Medicaid number in this locator. For providers who are given an Atypical Provider Number (API), this is the locator that will be used. Enter the provider number on the appropriate line that corresponds to the recipient name in locator 50.
58	**Insured's Name A-C Required**	**INSURED'S NAME** – Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the enrollee name when eligibility is verified. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card. Enter the insured's name used by the primary payer identified on Line A, Locator 50. Enter the insured's name used by the secondary payer identified on Line B, Locator 50.

Locator		Instructions
		Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.
59	**Patient's Relationship to Insured A-C Required**	**Patient's Relationship to Insured** - Enter the code indicating the relationship of the insured to the patient. Note: Appropriate codes accepted by DMAS are: **Code:** / **Description:** 01 Spouse 18 Self 19 Child 21 Unknown 39 Organ Donor 40 Cadaver Donor 53 Life Partner G8 Other Relationship
60	**Insured's Unique Identification A-C Required**	**Insured's Unique Identification** - For lines A-C, enter the unique identification number of the person insured that is assigned by the payer organization shown on Lines A-C, Locator 50. **NOTE:** The Medicaid recipient identification number is 12 numeric digits.
61	(Insured) Group Name A-C	(Insured) Group Name - Enter the name of the group or plan through which the insurance is provided.
62	Insurance Group Number A-C	Insurance Group Number - Enter the identification number, control number, or code assigned by the carrier/administrator to identify the group under which the individual is covered.
63	**Treatment Authorization Code Required (if applicable)**	**Treatment Authorization Code** - Enter the 11 digits preauthorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid.
64	**Document Control Number** (DCN) **Required for adjustment and void claims**	**Document Control Number** - The control number assigned to the original bill by Virginia Medicaid as part of their internal claims reference number. **Note:** This locator is to be used to place the original Internal Control Number (ICN) for claims that are being submitted to adjust or void the original PAID claim.
65	Employer Name (of the Insured) A-C	Employer Name (of the Insured) **-** Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.
66	**Diagnosis and Procedure Code Qualifier Required**	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator) –** The qualifier that denotes the version of the International Classification of Diseases.

Locator		Instructions
67	**Principal Diagnosis Code Required**	**Principal Diagnosis Code** – Enter the ICD diagnosis code that describes the principal diagnosis (i.e., the condition established after study to chiefly responsible for occasioning the admission of the patient for care).
67 & 67A-Q	Present on Admission (POA) Indicator Required	Present on Admission (POA) Indicator – The eighth digit of the Principal, Other Diagnosis and External Cause of Injury Codes are to be indicated if: • the diagnosis was known at the time of admission, or • the diagnosis was clearly present, but not diagnosed, until after admission took place or • was a condition that developed during an outpatient encounter. **Note:** Not Required for Hospice Services
67 A thru Q	**Other Diagnosis Codes Required if applicable**	**Other Diagnosis Codes** Enter the diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. **DO NOT USE DECIMALS.**
68	**Special Note**	**Note:** Facilities may place the adjustment or void error reason code in this locator. If nothing here, DMAS will default to error codes: 1052 – miscellaneous void or 1053 – miscellaneous adjustment.
69	**Admitting Diagnosis Required**	**Admitting Diagnosis –** Enter the diagnosis code describing the patient's diagnosis at the time of admission. **DO NOT USE DECIMALS.**
70 a-c	Patient's Reason for Visit	Patient's Reason for Visit **–** Enter the diagnosis code describing the patient's reason for visit at the time of inpatient or unscheduled outpatient registration.
71	Prospective Payment System (PPS) Code	Prospective Payment System **–** Enter the PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72	**External Cause of Injury Required if applicable**	**External Cause of Injury** – Enter the diagnosis code pertaining to external causes of injuries, poisoning, or adverse effect. **DO NOT USE DECIMALS.**
73	Reserved	Reserved for Assignment by the NUBC
74	**Principal Procedure Code and Date Required if applicable**	**Principal Procedure Code and Date –** Enter the ICDprocedure code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date. **Note:** For outpatient claims, a procedure code must appear in this locator when revenue codes 0360-0369, 0420-0429, 0430-0439, and 0440-0449 (if covered by Medicaid) are used in Locator 42 or the claim will be rejected.

Locator		Instructions
74a-e	**Other Procedure Codes and Date Required if applicable**	**Other Procedure Codes and Date –** Enter the ICDprocedure codes identifying all significant procedures other than the principal procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. **DO NOT USE DECIMALS.**
75	Reserved	Reserved for assignment by the NUBC
76	**Attending Provider Name and Identifiers Required**	**Attending Provider Name and Identifiers** – Enter the individual who has overall responsibility for the patient's medical care and treatment reported in this claim. Inpatient: Enter the 9-digit number assigned by Medicaid for the physician attending the patient in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after until April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the attending physicians' NPI will be accepted in the "NPI" space. Outpatient: Enter the 9-digit number assigned by Medicaid for the physician who performs the principal procedure in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the physicians' NPI will be accepted in the "NPI" space. **Note:** The qualifier for this locator is '82' (Rendering Provider) whenever the legacy Medicaid number is entered. **Note:** If the NPI is in locator 56, then this locator must also have the attending providers NPI.

Locator		Instructions
77	**Operating Physician Name and Identifiers Required if applicable**	**Operating Physician Name and Identifiers** – Enter the name and the 9-digit number assigned by Medicaid of the individual with the primary responsibility for performing the surgical procedure(s). This is required when there is a surgical procedure on the claim. Inpatient: Enter the 9-digit number assigned by Medicaid for the operating physician attending the patient in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Complince, only the operating physicians' NPI will be accepted in the "NPI" space. Outpatient: Enter the 9-digit number assigned by Medicaid for the operating physician who performs the principal procedure in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the physicians' NPI will be accepted in the "NPI" space. **Note:** The qualifier for this locator is either '82' (Rendering Provider), 'DN' (Referring Provider) or 'ZZ' (Other Operating Physician) whenever the legacy Medicaid number is entered.
78 - 79	**Other Provider Name and Identifiers Required if applicable**	**Other Physician ID.** – Enter the 9 digit provider number assigned by Medicaid. For Hospice Providers: If revenue code 0658 is billed, then enter the nursing facility provider number in this locator. Please refer below to the time frame for entrance of either the legacy Medicaid provider number or the NPI. **Note:** Until DMAS has implemented the dual use period on March 26, 2007 the legacy Medicaid number or the providers NPI can be entered. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the physician's NPI will be accepted in the "NPI" space. **Note:** The qualifier for this locator is 'DN' (Referring Provider) whenever the legacy Medicaid number is entered.
80	**Remarks Field**	**Remarks Field** – Enter additional information necessary to adjudicate the claim. Enter a brief description of the reason for the submission of the adjustment or void. If there is a delay in filing, indicate the reason for the delay here and/or include an attachment. Provide other information necessary to adjudicate the claim.

Locator		Instructions
81	**Code-Code Field Required if applicable**	**Code-Code Field** – Enter the provider taxonomy code for the billing provider when the adjudication of the claim is known to be impacted. DMAS will be using this field to capture taxonomy for claims that are submitted with one NPI for multiple business types or locations (eg, Rehabilitative or Psychiatric units within an acute care facility; Home Health Agency with multiple locations). **Code B3 is to be entered in first (small) space and the provider taxonomy code is to be entered in the (second) large space. The third space should be blank.**

Note: Hospice providers with **one** NPI must use a taxonomy code when submitting claims for different business types. (one NPI for 2 or more Medicaid PIN)

Service Type Description	Taxonomy Code(s)
Community Based Hospice	251G00000X
Inpatient Hospice	351D00000X

If you have a question related to Taxonomy, please e-mail DMAS at NPI@dmas.virginia.gov.

Forward the original with any attachments for consideration of payment to:

Department of Medical Assistance Services

P.O. Box 27443

Richmond, Virginia 23261-7443

Maintain the Institution copy in the provider files for future reference.

UB-04 (CMS-1450) Adjustment Invoice and Void Invoice Instructions

To **adjust** a previously paid claim, complete the UB-04 CMS-1450 to reflect the proper conditions, services, and charges.

Type of Bill (Locator 4) **–** Enter code 0817, 0827 for inpatient Nursing Home Hospice Services or enter code 0837 for outpatient Hospice services.

Locator 64 – Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the remittance voucher.

- Locator 68 – Enter the four digit adjustment reason code (refer to the below listing for codes acceptable by DMAS.

- Remarks (Locator 80) **–** Enter an explanation for the adjustment.

NOTE: Inpatient Hospice claims cannot be adjusted if the following information is being changed. In order to correct these areas, the claim will need to be voided and resubmitted as an original claim.

- Admission Date
- From or Through Date
- Discharge Status
- Diagnosis Code(s)
- Procedure Code(s)

Acceptable Adjustment Codes:

Code	Description
1023	Primary Carrier has made additional payment
1024	Primary Carrier has denied payment
1025	Accommodation charge correction
1026	Patient payment amount changed
1027	Correcting service periods
1028	Correcting procedure/ service code

1029	Correcting diagnosis code
1030	Correcting charge
1031	Correcting units/visits/studies/procedures
1032	IC reconsideration of allowance, documented
1033	Correcting admitting, referring, prescribing, provider identification number
1053	Adjustment reason is in the Misc. Category

To **VOID** a previously paid claim, complete the following data elements on the UB-04 CMS-1450:

Type of Bill (Locator 4) **–** Enter code 0818, 0828 for inpatient Hospice services or enter code 0838 for outpatient Hospice services.

Locator 64 – Document Control Number **–** Enter the sixteen digit claim reference number of the paid claim to be voided. The claim reference number appears on the remittance voucher.

- Locator 68 – Enter the four digit void reason code (refer to the below listing for codes acceptable by DMAS.

Remarks (Locator 80) **–** Enter an explanation for the void.

Acceptable Void Codes:

Code	Description
1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge

1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available

Billing Instructions: Group Practice Billing Functionality

Providers defined in this manual are not eligible to submit claims as a Group Practice with the Virginia Medicaid Program. Group Practice claim submissions are reserved for independently enrolled fee-for-service healthcare practitioners (physicians, podiatrists, psychologists, etc.) that share the same Federal Employer Identification Number. Facilitybased organizations (NPI Type 2) and providers assigned an Atypical Provider Identifier (API) may not utilize group billing functionality.

Medicare Crossover: If Medicare requires you to submit claims identifying an individual Rendering Provider, DMAS will use the Billing Provider NPI to adjudicate the Medicare Crossover Claim. You will not enroll your organization as a Group Practice with Virginia Medicaid.

For more information on Group Practice enrollment and claim submissions using the CMS1500 (02-12), please refer to the appropriate practitioner Provider Manual found at www.dmas.virginia.gov.

Billing Instructions: Negative Balance Information

Negative balances occur when one or more of the following situations have occurred:

- Provider submitted adjustment/void request
- DMAS completed adjustment/void
- Audits
- Cost settlements
- Repayment of advance payments made to the provider by DMAS

In the remittance process the amount of the negative balance may be either off set by the total of the approved claims for payment leaving a reduced payment amount or may result in a negative balance to be carried forward. The remittance will show the amount as “less the negative balance” and it may also show “the negative balance to be carried forward.”

The negative balance will appear on subsequent remittances until it is satisfied. An example is if the claims processed during the week resulted in approved allowances of $1000.00 and the provider has a negative balance of $2000.00. A check will not be issued, and the remaining $1000.00 outstanding to DMAS will carry forward to the next remittance.

Billing Instructions: EDI Billing (Electronic Claims)

Please refer to X-12 Standard Transactions & our Companion Guides that are listed in the chapter.

Billing Instructions: Invoice Processing

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Upon receipt, a claim is scanned or directly keyed, assigned a claim reference number, and entered into the MMIS system. The claim is then placed in one of the following categories:

- **Remittance Voucher (Payment Voucher)** - DMAS sends a Remittance Voucher with each payment. This voucher lists the approved, pended, denied, adjusted, or voided claims and should be kept in the provider's permanent files. The first page of the voucher contains a space for special messages from DMAS. The sections of the Remittance Voucher are:
  - **Approved** - These are claims which have been approved and for which the provider is being reimbursed;
  - **Pended** - These claims are being reviewed. The final adjudication of this claim will be a later Remittance Voucher;
  - **Denied** - These claims are denied and are not reimbursable by DMAS as submitted (e.g., the submission of a duplicate claim of a previously submitted claim);
  - **Debit** - This section lists any formerly paid claims which have been adjusted, thereby creating a positive balance;
  - **Credit** - This section lists any formerly paid claims which have been either adjusted or voided and have created a negative balance; and
  - **Provider Number** - The nine-digit API or NPI identification number assigned to the individual provider. Include this number in all correspondence with DMAS.
- **No Response** - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form.

The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.

Denial Messages For Nursing Facility Residents

A denied claim is unacceptable for payment for the stated reason. Proper interpretation of the denial message will allow proper resubmission of an acceptable claim.

RUG Code Invalid - Check the RUG code to confirm the RUG grouper and version and revenue code 0022 for the dates of service.

Action to Take: Resubmit claim with correct RUG code with revenue code 0022 with zero (0) charges.

Invalid RUG Units – Check if the sum of the RUG units match the covered days submitted on the claim.

Action to Take: Resubmit the claim with the RUG units that match the covered days for the billing period.

Calculated RUG Amount is Zero – Confirm all claim information submitted is correct.

Action to Take: Resubmit the claim with corrected claim information.

DMAS has removed the previous rate tables from the exhibit section in this manual. Hospice rates can be found on our website: www.dmas.virginia.gov. Click on Provider Services and then click on Hospice Rate.

UB-04 (CMS-1450) BILLING INSTRUCTIONS

Instructions for completing the UB-04 cms-1450 claim form

DMAS will allow the use of this claim form beginning with claims received on or after April 1, 2007.

Locator		Instructions
1	**Provider Name, Address, Telephone Required**	**Provider Name, Address, Telephone** - Enter the provider's name, complete mailing address and telephone number of the provider that is submitting the bill and which payment is to be sent. Line 1. Provider Name Line 2. Street Address Line 3. City. State, Line 4. Zip Code- **NOTE:** DMAS will need to have the 9 digit zip code on line four, left justified for adjudicating the claim if the provider has provided only one NPI and the servicing provider has multiple site locations for this service. **Note**: DMAS **does not** require telephone/fax numbers.
2	**Pay to Name & Address Required if Applicable**	**Pay to Name & Address** - Enter the address of the provider where payment is to be sent, if different than Locator 1.
3a	**Patient Control Number Required**	**Patient Control Number** - Enter the patient's unique financial account number which does not exceed 20 alphanumeric characters.
3b	**Medical/Health Record Required**	**Medical/Health Record** - Enter the number assigned to the patient's medical/health record by the provider. This number cannot exceed 24 alphanumeric characters.
4	**Type of Bill Required**	**Type of Bill** - Enter the code as appropriate. Valid codes for Virginia Medicaid are: 0811 Original Inpatient Nursing Home Hospice Invoice 0812 Interim Inpatient Nursing Home Hospice Claim Form* 0813 Continuing Inpatient Nursing Home Hospice Claim Invoice* 0814 Last Inpatient Nursing Home Hospice Claim Invoice* 0817 Adjustment Inpatient Nursing Home Hospice Invoice 0818 Void Inpatient Nursing Home Hospice Invoice
	Note:	For the above bill types, the revenue code that is billed for Nursing Facility services which are provided by Hospice is 0658- Nursing Facility Resident 0821 Original Inpatient Hospital Hospice Invoice 0822 Interim Inpatient Hospital Hospice Claim Form* 0823 Continuing Inpatient Hospital Hospice Claim Invoice* 0824 Last Inpatient Hospital Hospice Claim Invoice* 0827 Original Inpatient Hospital Hospice Invoice Adjustment 0828 Original Inpatient Hospital Hospice Invoice- Void
	Note:	For the above bill types, the revenue code that is billed for Inpatient Hospital Hospice Services which are provided by Hospice is 0655 - Inpatient Respite Care. 0831 Original Outpatient Invoice 0837 Adjustment Outpatient Invoice 0838 Void Outpatient Invoice

Locator		Instructions
		These below are for Medicare Crossover Claims Only
	Note:	For the above bill types, the revenue code that is billed for Nursing Home Outpatient Services which are provided by Hospice are 0651- Routine Home Care **OR** 0652 - Continuous Home Care.
5	Federal Tax Number Not Required	Federal Tax Number - The number assigned by the federal government for tax reporting purposes
6	**Statement Covered Period Required**	**Statement Covered Period -** Enter the beginning and ending service dates reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day.
7	Reserved for assignment by the NUBC	Reserved for assignment by the NUBC **NOTE: This locator on the UB 92 contained the covered days of care. Please review locator 39 for appropriate entry of the covered and non-covered days.**
8	**Patient Name/Identifier Required**	**Patient Name/Identifier** - Enter the last name, first name and middle initial of the patient on line b. Use a comma or space to separate the last and first name.
9	Patient Address	Patient Address **-** Enter the mailing address of the patient. 1. Street address 2. City 3. State 4. Zip Code (9 digits) 5. Country Code if other than USA
10	**Patient Birthdate Required**	**Patient Birthdate -** Enter the date of birth of the patient. Note: The format for birthdate is MMDDYYYY. This is the only locator that the 4-digit year is to be used.
11	**Patient Sex Required**	**Patient Sex -** Enter the sex of the patient as recorded at admission, outpatient or start of care service. M = male; F = female and U = unknown
12	**Admission/Start of Care Required**	**Admission/Start of Care -** The start date for this episode of care. For general Hospice this date is the date hospice began. For patients already in a nursing home facility, but elect hospice services the date hospice care began is to be entered. NOT the admission date to the nursing home.
13	**Admission Hour Required**	**Admission Hour -** Enter the hour during which the patient was admitted for inpatient or outpatient care. **Note**: Military time is used as defined by NUBC.

Locator		Instructions

14 Priority (Type) of Visit Required

Priority (Type) of Visit - Enter the code indicating the priority of this admission/visit. Appropriate codes accepted by DMAS for hospice are:

Code	Description
3	Elective **-** patient's condition permits adequate time to schedule the services
9	Information not available

15 Source of Referral for Admission or Visit Required

Source of Referral for Admission or Visit - Enter the code indicating the source of the referral for this admission or visit.
Note: Appropriate codes accepted by DMAS are:

Code:	Description
1	Physician Referral
2	Clinic Referral
4	Transfer from Another Acute Care Facility
5	Transfer from a Skilled Nursing Facility
6	Transfer from Another Health Care Facility (long term care facilities, rehabilitative and psychiatric facility
9	Information not available

16 Discharge Hour Required

Discharge Hour - Enter the code indicating the discharge hour of the patient from inpatient care. **Note:** Military time is used as defined by NUBC

17 Patient Discharge Status Required

Patient Discharge Status - Enter the code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill (statement covered period, locator 6). Note: If the patient was a one-day stay, enter code "01". Appropriate codes accepted by DMAS are:

Code	Description
01	Discharged to Home
02	Discharged/transferred to Short term General Hospital for Inpatient Care
03	Discharged/transferred to Skilled Nursing Facility
04	Discharged/transferred to Intermediate Care Facility
05	Discharged/transferred to Another Facility not Defined Elsewhere
07	Left Against Medical Advice or Discontinued Care
20	Expired
30	Still a Patient
50	Hospice – Home
51	Hospice – Medical Care Facility
61	Discharged/transferred to Hospital Based Medicare Approved Swing Bed

Locator		Instructions
18 thru 28	**Condition Codes Required if applicable**	**Condition Codes** – Enter the code(s) in alphanumeric sequence used to identify conditions or events related to this bill that may affect adjudication. **Note**: DMAS limits the number of condition codes to maximum of 8 on one claim. These codes are used by DMAS in the adjudication of claims: **Code** **Description** 39 Private Room Medically Necessary 40 Same Day Transfer A1 EPSDT A4 Family Planning
29	**Accident State**	**Accident State** – Enter if known the state (two digit state abbreviation) where the accident occurred.
30	**Crossover Part A Indicator**	**Note:** DMAS is requiring for Medicare Part A crossover claims that the word **"CROSSOVER"** be in this locator
31 thru 34	**Occurrence Code and Dates Required if applicable**	**Occurrence Code and Dates –** Enter the code and associated date defining a significant event relates to this bill. Enter codes in alphanumeric sequence. An example of how providers should identify Medicare coverage exhausted on a Medicaid claim is A3= MDCR Exhaust
35 thru 36	**Occurrence Span Code and Dates Required if applicable**	**Occurrence Span Code and Dates –** Enter the code and related dates that identify an event relating to the payment of the claim. Enter codes in alphanumeric sequence. **For nursing facility residents, report occurrence span code (50) and the Medicaid Assessment Reference Date (ARD) date in the occurrence span dates for each RUG code. Multiple occurrence code 50 entries and occurrence span dates may be entered.**
37	Reserved	Reserved For NUBC Assignment
38	Responsible Party Name and Address	Responsible Party Name and Address – Enter the name and address of the party responsible for the bill.

Locator		Instructions
39 thru 41	**Value codes and Amount Required**	**Value Codes and Amount -** Enter the appropriate code(s) to relate amounts or values to identify data elements necessary to process this claim. **Note:** DMAS will be capturing the number of covered or non-covered day(s) or units for inpatient and outpatient service(s) with these required value codes: 80. Enter the number of covered days for inpatient hospitalization or the number of days for re-occurring outpatient claims. 81. Enter the number of non-covered days for inpatient hospitalization **AND** One of the following codes **must** be used to indicate the coordination of third party insurance carrier benefits: 82. No Other Coverage 83. Billed and Paid (enter amount paid by primary carrier) 85. Billed Not Covered/No Payment For Part A Medicare Crossover Claims, the following codes must be used with one of the third party insurance carrier codes from above: A1 Deductible from Part A A2 Coinsurance from Part A Other codes may also be used if applicable. The a, b, or c line containing this above information should Cross Reference to Payer Name (Medicaid) in Locator 50 A, B, C.
42	**Revenue Code Required**	**Revenue Codes** - Enter the appropriate revenue code(s) for the service provided. Note: • Revenue codes are four digits, leading zero, left justified and should be reported in ascending numeric order, • Multiple services for the same item, providers should aggregate the service under the assigned revenue code and then the total number of units that represents those services, • DMAS has a limit of five pages for one claim, • The Total Charge revenue code (0001) should be the last line of the last page of the claim. 0651 Routine home care is in-home care that is not continuous (less than 8 hours per day). (one unit = 1 day) Note: As of January 1, 2016, a higher base payment for the first 60 days of hospice care and a reduced base payment rate for days 61 and thereafter 0652 Continuous home care consists of in-home care that is predominantly nursing care and is provided as short-term crisis care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home care. (one unit = 1 hour)

Locator		Instructions
		0655 Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice or hospital) to relieve the primary caregiver(s) providing in-home care for the recipient. No more than five consecutive days of respite care will be allowed (one unit = 1 day). Payment for the sixth day and any subsequent days of respite care is made at the routine home care rate (Z9430). 0656 General inpatient care may be provided in an approved freestanding hospice or hospital. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting. (one unit = 1 day) 0658 Nursing facility resident who elected the hospice benefit (one unit = 1 day). Revenue code 0658 must be billed in conjunction with either revenue code 0651 (routine home care) or 0652 (continuous home care), which are billed as outpatient services with bill type 0831. Claims must also contain one revenue code 0022 for each distinct billing period of the nursing facility stay. Effective with dates of service 07/01/2019 and after, Hospice providers will be reimbursed 100% of the Medicaid per diem rate for the nursing facility in addition to reimbursement for either routine or continuous home care. 0551 Skilled Nursing Visit – to be used when submitting charges representative of a visit by a Registered Nurse within the member's last 7 days of life. Revenue code 0551 must be billed in conjunction with procedure code G0299.(one unit = 15 minutes, max 16 per day). Note: a corresponding 0651 – Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment. 0561 Medical Social Service Visit – to be used to be used when submitting charges representative of a visit by a Clinical Social Worker within the member's last 7 days of life. Revenue code 0561 must be billed in conjunction with procedure code G0155 (one unit = 15 minutes, max 16 per day). Note: a corresponding 0651 – Routine Home Care charge for the same date of service must also be submitted for consideration of SIA payment.
43	**Revenue Description Required**	**Revenue Description -** Enter the standard abbreviated description of the related revenue code categories included on this bill.

Locator		Instructions
44	**HCPCS/Rates/ HIPPS Rate Codes Required (if applicable)**	**HCPCS/Rates/HIPPS Rate Codes -** Inpatient: Enter the accommodation rate. For nursing facility residents, report the RUG code in the first three digits HIPPS rate code locator and the assessment code (reason for assessment) or modifier in the last two digits of the HIPPS rate code. Outpatient: The following codes are to be used only when submitting charges applicable to and for consideration of the SIA Payment. G0299 - direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting. G0155 - Services of clinical social worker in home health or hospice settings, each 15 minutes.
45	**Service Date Required if applicable**	**Service Date -** Enter one line item entry per revenue code for each date the outpatient service was provided.
46	**Service Units Required**	**Service Units -** Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate. Outpatient: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit). For nursing facility residents, the total accommodation days for revenue code 0658 should equal total units for each revenue code 0022 line.
47	**Total Charges Required**	**Total Charges -** Enter the total charge(s) for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges include both covered and non covered charges. **Note:** Use code “0001” for TOTAL. For nursing facility residents, the total charges for revenue code 0022 should be zero.
48	**Non-Covered Charges Required if applicable**	**Non-Covered Charges -** To reflect the non-covered charges for the primary payer as it pertains to the related revenue code.
49	Reserved	Reserved for Assignment by the NUBC.
50	**Payer Name A-C. Required**	**Payer Name -** Enter the payer from which the provider may expect some payment for the bill. A Enter the primary payer identification. B Enter the secondary payer identification, if applicable. C Enter the tertiary payer if applicable. When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C. This also applies to the Temporary Detention and Emergency Custody Order claims.

Locator		Instructions
51	Health Plan Identification Number A-C	Health Plan Identification Number **-** The number assigned by the health plan to identify the health plan from which the provider might expect payment for the bill. **NOTE:** DMAS will no longer use this locator to capture the Medicaid provider number. Refer to locators 56 and 57.
52	Release of Information Certification Indicator A-C	Release of Information Certification Indicator - Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization.
53	Assignment of Benefits Certification Indicator A-C	Assignment of Benefits Certification Indicator - Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.
54	**Prior Payments – Payer A,B,C Required (if applicable)**	**Prior Payments Payer** – Enter the amount the provider has received (to date) by the health plan toward payment of this bill.
55	Estimated Amount Due A,B,C,	Estimated Amount Due – Payer – Enter the amount by the provider to be due from the indicated payer (estimated responsibility less prior payments).
56	**NPI Required**	**National Provider Identification** – Enter your NPI. Once DMAS is in the dual use period (March 26, 2007), providers will submit their NPI in this locator on the UB 04. Until March 26, 2007, providers should enter their legacy Medicaid number in locator 57.
57A thru C	**Other Provider Identifier Required (if applicable)**	**Other Provider Identifier** – Enter your legacy Medicaid provider number in this locator until DMAS is accepting NPI for claims processing which are claims submitted prior to March 26, 2007. After NPI Compliance, DMAS will not accept claims received with the legacy Medicaid number in this locator. For providers who are given an Atypical Provider Number (API), this is the locator that will be used. Enter the provider number on the appropriate line that corresponds to the recipient name in locator 50.
58	**Insured's Name A-C Required**	**INSURED'S NAME** – Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the enrollee name when eligibility is verified. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card. Enter the insured's name used by the primary payer identified on Line A, Locator 50. Enter the insured's name used by the secondary payer identified on Line B, Locator 50.

Locator		Instructions
		Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.
59	**Patient's Relationship to Insured A-C Required**	**Patient's Relationship to Insured** - Enter the code indicating the relationship of the insured to the patient. Note: Appropriate codes accepted by DMAS are: **Code:** / **Description:** 01 Spouse 18 Self 19 Child 21 Unknown 39 Organ Donor 40 Cadaver Donor 53 Life Partner G8 Other Relationship
60	**Insured's Unique Identification A-C Required**	**Insured's Unique Identification** - For lines A-C, enter the unique identification number of the person insured that is assigned by the payer organization shown on Lines A-C, Locator 50. **NOTE:** The Medicaid recipient identification number is 12 numeric digits.
61	(Insured) Group Name A-C	(Insured) Group Name - Enter the name of the group or plan through which the insurance is provided.
62	Insurance Group Number A-C	Insurance Group Number - Enter the identification number, control number, or code assigned by the carrier/administrator to identify the group under which the individual is covered.
63	**Treatment Authorization Code Required (if applicable)**	**Treatment Authorization Code** - Enter the 11 digits preauthorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid.
64	**Document Control Number** (DCN) **Required for adjustment and void claims**	**Document Control Number** - The control number assigned to the original bill by Virginia Medicaid as part of their internal claims reference number. **Note:** This locator is to be used to place the original Internal Control Number (ICN) for claims that are being submitted to adjust or void the original PAID claim.
65	Employer Name (of the Insured) A-C	Employer Name (of the Insured) **-** Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.
66	**Diagnosis and Procedure Code Qualifier Required**	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator) –** The qualifier that denotes the version of the International Classification of Diseases.

Locator		Instructions
67	**Principal Diagnosis Code Required**	**Principal Diagnosis Code** – Enter the ICD diagnosis code that describes the principal diagnosis (i.e., the condition established after study to chiefly responsible for occasioning the admission of the patient for care).
67 & 67A-Q	Present on Admission (POA) Indicator Required	Present on Admission (POA) Indicator – The eighth digit of the Principal, Other Diagnosis and External Cause of Injury Codes are to be indicated if: • the diagnosis was known at the time of admission, or • the diagnosis was clearly present, but not diagnosed, until after admission took place or • was a condition that developed during an outpatient encounter. **Note:** Not Required for Hospice Services
67 A thru Q	**Other Diagnosis Codes Required if applicable**	**Other Diagnosis Codes** Enter the diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. **DO NOT USE DECIMALS.**
68	**Special Note**	**Note:** Facilities may place the adjustment or void error reason code in this locator. If nothing here, DMAS will default to error codes: 1052 – miscellaneous void or 1053 – miscellaneous adjustment.
69	**Admitting Diagnosis Required**	**Admitting Diagnosis –** Enter the diagnosis code describing the patient's diagnosis at the time of admission. **DO NOT USE DECIMALS.**
70 a-c	Patient's Reason for Visit	Patient's Reason for Visit **–** Enter the diagnosis code describing the patient's reason for visit at the time of inpatient or unscheduled outpatient registration.
71	Prospective Payment System (PPS) Code	Prospective Payment System **–** Enter the PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72	**External Cause of Injury Required if applicable**	**External Cause of Injury** – Enter the diagnosis code pertaining to external causes of injuries, poisoning, or adverse effect. **DO NOT USE DECIMALS.**
73	Reserved	Reserved for Assignment by the NUBC
74	**Principal Procedure Code and Date Required if applicable**	**Principal Procedure Code and Date –** Enter the ICDprocedure code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date. **Note:** For outpatient claims, a procedure code must appear in this locator when revenue codes 0360-0369, 0420-0429, 0430-0439, and 0440-0449 (if covered by Medicaid) are used in Locator 42 or the claim will be rejected.

Locator		Instructions
74a-e	**Other Procedure Codes and Date Required if applicable**	**Other Procedure Codes and Date –** Enter the ICDprocedure codes identifying all significant procedures other than the principal procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. **DO NOT USE DECIMALS.**
75	Reserved	Reserved for assignment by the NUBC
76	**Attending Provider Name and Identifiers Required**	**Attending Provider Name and Identifiers** – Enter the individual who has overall responsibility for the patient's medical care and treatment reported in this claim. Inpatient: Enter the 9-digit number assigned by Medicaid for the physician attending the patient in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after until April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the attending physicians' NPI will be accepted in the "NPI" space. Outpatient: Enter the 9-digit number assigned by Medicaid for the physician who performs the principal procedure in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the physicians' NPI will be accepted in the "NPI" space. **Note:** The qualifier for this locator is '82' (Rendering Provider) whenever the legacy Medicaid number is entered. **Note:** If the NPI is in locator 56, then this locator must also have the attending providers NPI.

Locator		Instructions
77	**Operating Physician Name and Identifiers Required if applicable**	**Operating Physician Name and Identifiers** – Enter the name and the 9-digit number assigned by Medicaid of the individual with the primary responsibility for performing the surgical procedure(s). This is required when there is a surgical procedure on the claim. Inpatient: Enter the 9-digit number assigned by Medicaid for the operating physician attending the patient in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Complince, only the operating physicians' NPI will be accepted in the "NPI" space. Outpatient: Enter the 9-digit number assigned by Medicaid for the operating physician who performs the principal procedure in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the physicians' NPI will be accepted in the "NPI" space. **Note:** The qualifier for this locator is either '82' (Rendering Provider), 'DN' (Referring Provider) or 'ZZ' (Other Operating Physician) whenever the legacy Medicaid number is entered.
78 - 79	**Other Provider Name and Identifiers Required if applicable**	**Other Physician ID.** – Enter the 9 digit provider number assigned by Medicaid. For Hospice Providers: If revenue code 0658 is billed, then enter the nursing facility provider number in this locator. Please refer below to the time frame for entrance of either the legacy Medicaid provider number or the NPI. **Note:** Until DMAS has implemented the dual use period on March 26, 2007 the legacy Medicaid number or the providers NPI can be entered. The UB-04 form will be accepted on or after April 1, 2007, and then the NPI may be entered in the "NPI" space. After NPI Compliance, only the physician's NPI will be accepted in the "NPI" space. **Note:** The qualifier for this locator is 'DN' (Referring Provider) whenever the legacy Medicaid number is entered.
80	**Remarks Field**	**Remarks Field** – Enter additional information necessary to adjudicate the claim. Enter a brief description of the reason for the submission of the adjustment or void. If there is a delay in filing, indicate the reason for the delay here and/or include an attachment. Provide other information necessary to adjudicate the claim.

Locator		Instructions
81	**Code-Code Field Required if applicable**	**Code-Code Field** – Enter the provider taxonomy code for the billing provider when the adjudication of the claim is known to be impacted. DMAS will be using this field to capture taxonomy for claims that are submitted with one NPI for multiple business types or locations (eg, Rehabilitative or Psychiatric units within an acute care facility; Home Health Agency with multiple locations). **Code B3 is to be entered in first (small) space and the provider taxonomy code is to be entered in the (second) large space. The third space should be blank.**

Note: Hospice providers with **one** NPI must use a taxonomy code when submitting claims for different business types. (one NPI for 2 or more Medicaid PIN)

Service Type Description	Taxonomy Code(s)
Community Based Hospice	251G00000X
Inpatient Hospice	351D00000X

If you have a question related to Taxonomy, please e-mail DMAS at NPI@dmas.virginia.gov.

Forward the original with any attachments for consideration of payment to:

Department of Medical Assistance Services

P.O. Box 27443

Richmond, Virginia 23261-7443

Maintain the Institution copy in the provider files for future reference.

UB-04 (CMS-1450) Adjustment Invoice and Void Invoice Instructions

To **adjust** a previously paid claim, complete the UB-04 CMS-1450 to reflect the proper conditions, services, and charges.

Type of Bill (Locator 4) **–** Enter code 0817, 0827 for inpatient Nursing Home Hospice Services or enter code 0837 for outpatient Hospice services.

Locator 64 – Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the remittance voucher.

- Locator 68 – Enter the four digit adjustment reason code (refer to the below listing for codes acceptable by DMAS.

- Remarks (Locator 80) **–** Enter an explanation for the adjustment.

NOTE: Inpatient Hospice claims cannot be adjusted if the following information is being changed. In order to correct these areas, the claim will need to be voided and resubmitted as an original claim.

- Admission Date
- From or Through Date
- Discharge Status
- Diagnosis Code(s)
- Procedure Code(s)

Acceptable Adjustment Codes:

Code	Description
1023	Primary Carrier has made additional payment
1024	Primary Carrier has denied payment
1025	Accommodation charge correction
1026	Patient payment amount changed
1027	Correcting service periods
1028	Correcting procedure/ service code

1029	Correcting diagnosis code
1030	Correcting charge
1031	Correcting units/visits/studies/procedures
1032	IC reconsideration of allowance, documented
1033	Correcting admitting, referring, prescribing, provider identification number
1053	Adjustment reason is in the Misc. Category

To **VOID** a previously paid claim, complete the following data elements on the UB-04 CMS-1450:

Type of Bill (Locator 4) **–** Enter code 0818, 0828 for inpatient Hospice services or enter code 0838 for outpatient Hospice services.

Locator 64 – Document Control Number **–** Enter the sixteen digit claim reference number of the paid claim to be voided. The claim reference number appears on the remittance voucher.

- Locator 68 – Enter the four digit void reason code (refer to the below listing for codes acceptable by DMAS.

Remarks (Locator 80) **–** Enter an explanation for the void.

Acceptable Void Codes:

Code	Description
1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge

1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available